Academia’s Role in Community Access to Child Health

ABBREVIATIONS. CATCH, Community Access to Child Health; COAT, Community-oriented Advocacy Training.

Ideally the mission of every academic health center should encompass the core values of the Community Access to Child Health (CATCH) Program: improving child health, increasing access to health care, and promoting advocacy at the community level. As university hospitals face challenges to improve child health through research, clinical service, and teaching, promoting advocacy at the community level should occur as a natural progression. Certainly, many of the key findings of the CATCH evaluation as they apply to pediatricians in practice apply just as well to pediatricians in the academic setting. Pediatric faculty with exposure to community child health issues early in their careers seem to be more likely to advance efforts within the CATCH agenda. Relationships of individual faculty in academic institutions to local and/or state public health agencies can play a key role in enabling community projects to be successful. Finally, because medical students and residents spend a majority of their time in contact with academic faculty, the role of the academic institution in introducing advocacy skills is apparent.

Throughout the brief history of CATCH, it is apparent that one of the major keys to success is the leadership of individuals willing to dedicate their energy and professional careers to children’s issues. Creative partnerships involving community and medical liaisons often gave CATCH projects the innovative boost they needed to prosper. Of particular importance is the recognition that CATCH has an evolving definition. Like any program, CATCH is dependent on the interests of its leaders, the needs of the community it serves, and the power of its financial supporters. With such variables, the program has evolved from an access to child health program (with a focus on issues of providing health care to underserved populations) to an organizational unit within the Department of Community Pediatrics of the American Academy of Pediatrics.

Pediatricians are natural advocates for children, and we have a long, distinguished history of advocacy dating back to the founder of American Pediatrics, Abraham Jacobi. The first full-time chair of our department, Dr Julius B. Richmond, taught that “When pediatricians advocate only for pediatricians, no one listens; when pediatricians advocate for children, everyone listens” (J.B. Richmond, personal communication). In our department at the State University of New York Health Science Center in Syracuse, NY, the questions that kept recurring in discussions at our Residency Committee and within the faculty at large were “How can we teach advocacy?” and “How to do it?.” The most recent iteration of the Residency Review Committee guidelines regarding advocacy training states that programs should provide “…structured educational experiences that prepare residents for the role of advocate for the health of children within the community. These should include both didactic and experiential components that may be integrated into other parts of the curriculum… or they maybe designed as distinct longitudinal or block rotations.”

In general, the advocacy training program in our department followed an evolution of philosophy similar to the CATCH Program. We became involved with CATCH in 1995, through the visiting professorship of Dr Thomas DeWitt. At the time of his visit, we had just completed a 1-year trial effort offering elective experiences in advocacy to our pediatric residents. Although we did not want to limit ourselves to political advocacy, we based our trial on the published success of the advocacy elective in Seattle, WA. Many of our faculty are advocates for underserved populations—working with abused children or children with no primary care providers. We found that few residents elected the rotation, and those who did were unable to accomplish many of their goals. When Dr Dewitt visited, we were poised to begin a required 3-year advocacy curriculum. His visit catalyzed our efforts and gave us a new perspective on how to proceed. By incorporating the GNOME (Goals, Needs assessment, Objectives, Methods, and Evaluation) into the resident’s training, we changed the focus to community pediatrics. Our training program Community Oriented Advocacy Training (COAT) was derived from Tom Dewitt’s Community Oriented Primary Care Program.

It is a 3-year-long effort to help our residents learn about advocacy as part of their future role as pediatricians in a broader context—to think in terms of the needs of populations of children in addition to individual children. The goals of our program are to:

- Provide residents with advocacy experiences without interfering with other important residency experiences;
- Develop a community-based method of teaching advocacy skills; and
- Develop new coalitions within community agencies building on child advocacy interests of residents, clinical faculty, and full-time faculty.
Over the last 4 years, the COAT program has evolved. With a CATCH planning grant, we were able to develop and initiate our first year of community partnerships. The residents were divided into three teams, each assigned a faculty member to mentor it and then taught specific skills. Over a series of eight 1-hour workshops, the residents were introduced to a variety of concepts. They were presented with various community programs (community leaders were invited), taught skills for doing a needs assessment and performing evaluations, learned about communication skills and coalition building, and given a bus tour of some of the neighborhoods. Monthly meetings are held throughout the 3 years; written feedback and regular departmental presentations are required. In June 1998, the first graduating residents presented the results of their advocacy efforts at a departmental grand rounds. The projects included handgun injury prevention, a window lock program, and a school-based violence awareness program. Each project had varying success. Whether the project was successful in terms of its effect on the community was less significant than the fact that every resident learned about advocacy by participating actively in the advocacy process.

We learned that many of our residents have already had advocacy experiences before the start of their residency (eg, working with children with developmental handicaps, working in developing nations), and we build on that experience. On the other hand, not every resident is ready for being an advocate for children early in training. The CATCH evaluation described this as a “dormancy” phase. We prefer to consider it an incubation period. Just as a resident learns to master the internship by evaluating one patient at a time and then eventually is able to supervise an entire ward, there is no magic moment when a physician is able to understand the difference between one-on-one patient advocacy and advocating for community pediatric issues.

We have reintroduced the concept of case advocacy early in the first year, so that residents can work through some of the skills needed for advocacy before working on a larger project. We have increased our focus on communication skills for interaction with nonmedical professionals and included a topic on project management during the workshop series.

Two unanticipated benefits were realized from the inception of the COAT program. First, the program provided a structure for a group of residents to have a collegial experience. By working together on a conceptual project, they all begin on common intellectual ground and learn about teamwork and consensus-building. Second, the Pediatric Department developed several new and interesting community liaisons with agencies that were concerned with child health. This was not only of benefit to the residents on individual projects, but became a networking resource for the faculty.

Teaching advocacy skills to pediatric residents or medical students cannot be accomplished quickly. Although it might be easier for residents/students to work on the successful projects of faculty members, educators need to be aware of the value to the student/resident of experiencing the real challenges of working on previously unchartered child health issues. Every generation should have its own leaders. Promotion of community-based activities during residency training, activities that spark the advocacy flame, is required for the continuing success of CATCH efforts and for growth of new exciting initiatives for children.

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